APPENDIX 9

Department of Health & Social Services
Division of Health
DOH-1062 (10/90)

HEALTHCHECK ADOLESCENT REVIEW

To be handed to adolescents 12 and over at the screening clinic.

Sometimes it is easier to talk about things this way. If you wish, circle YES or NO for each question and give this paper to the nurse... It will be returned to you.

1. Do you think something is wrong with your general health?	YES	NO
2. Do you feel you have to exercise more than 1 hr every day or else you feel bad about yourself?	YES	NO
3. Are you often upset?	YES	NO
4. Do you think something is wrong with your body development?	YES	NO
5. Do you think something is wrong with your weight and have you tried to lose or gain weight? How? _____	YES	NO
6. Is something slowing your progress in school?	YES	NO
7. Is something slowing your progress at work?	YES	NO
8. Are you having difficulties at home?	YES	NO
9. Do you have difficulty making friends when you are out?	YES	NO
10. Do you think something is wrong with your sex feelings?	YES	NO
11. Do you think something is wrong with your heart?	YES	NO
12. Do you think something is wrong with your skin?	YES	NO
13. Do you think something is wrong with your eyes?	YES	NO
14. Do you cough much or have breathing trouble?	YES	NO
15. Are you concerned about your stomach or bowels?	YES	NO
16. Do you think you have cancer? Where? _____	YES	NO
17. Does it "burn when you urinate?"	YES	NO
18. Do you have muscle or joint pain?	YES	NO
19. Do you have questions about drinking or use of drugs?	YES	NO
20. Do you have questions about pregnancy or birth control?	YES	NO
21. Do you have questions about discharge from your sex organs or sexually transmitted diseases?	YES	NO
22. Do you have questions about masturbation?	YES	NO

23. If you have questions or concerns about any of the following, we will be able to give you places and/or names to contact for further answers:

1 Dating, Going Steady	2 School Problems	3 Birth Control	4 Pregnancy
5 Drugs	6 Abortion	7 Sexually Transmitted Diseases	8 Weight Control

MALES ONLY

24. Do you have concerns about "wet dreams?"	YES	NO
25. Do you have concerns about size of your sex organ?	YES	NO

FEMALES ONLY

26. Have you started your periods? When _____ When was your last period? _____	YES	NO
27. How often do you get them? _____		
28. Do you have problems with your periods?	YES	NO
29. Do you take any medicine for them?	YES	NO
30. Have you ever had problems with a discharge, bleeding or anything else between your periods?	YES	NO
31. Please answer the following if you think you are pregnant:		
Do you live in a house built before 1950 where there is paint peeling?	YES	NO
Do you have a hobby that includes lead bullets, lead weights for fishing or lead glass?	YES	NO
Do you eat non-food items such as clay dirt, azarcon, Pay-loo-ah or Greta?	YES	NO

ANY OTHER COMMENTS OR QUESTIONS?